U.S. Department of Labor

Office of Administrative Law Judges
36 E. 7th St., Suite 2525
Cincinnati, Ohio 45202

(513) 684-3252
(513) 684-6108 (FAX)

Issue Date: 26 December 2006

In the Matter of:

D.V., Case No.: 2004-BLA-00087
On behalf of H.V.,
Claimant

v.

MOUNTAIN LAUREL RESOURCES CO.,
Employer

WEST VIRGINIA COAL-WORKERS' PNEUMOCONIOSIS FUND,
Carrier

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

Appearances:

D.V.
Pro Se Claimant

Robert Weinberger, Esq.
West Virginia Coal Workers' Pneumoconiosis Fund
Charleston, West Virginia
For the Employer/Carrier

Before: Alice M. Craft
Administrative Law Judge

DECISION AND ORDER DENYING REQUEST FOR MODIFICATION

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. § 901, *et seq.* The Act and implementing regulations, 20 CFR Parts 410, 718, 725, and 727, provide compensation and other benefits to living coal miners who are totally disabled due to pneumoconiosis and their dependents, and surviving dependents of coal miners whose death was due to pneumoconiosis. The Act and regulations define pneumoconiosis, commonly known as black lung disease, as a chronic dust disease of the lungs and its sequelae, including

respiratory and pulmonary impairments, arising out of coal mine employment. 30 U.S.C. § 902(b); 20 CFR § 718.201 (2006). In this case, the Claimant alleges that her husband, the Miner, was totally disabled due to pneumoconiosis.

I conducted a hearing on this claim on August 11, 2004, in Beckley, West Virginia. Both parties were afforded a full opportunity to present evidence and argument, as provided in the Rules of Practice and Procedure before the Office of Administrative Law Judges, 29 CFR Part 18 (2006). At the hearing, the Claimant and her and the Miner's son were witnesses. Transcript ("Tr.") at 10-16, 16-20. Director's Exhibits ("DX") 1-43 were admitted into evidence without objection. Tr. at 8. The record was held open after the hearing to allow the parties to submit closing arguments. The Employer submitted a closing argument, and the record is now closed.

In reaching my decision, I have reviewed and considered the entire record, including all exhibits admitted into evidence, the testimony at the hearing and the arguments of the parties.

PROCEDURAL HISTORY

The Miner filed his initial claim on February 16, 1994. DX 1 (DX 27-1). The District Director of the Office of Workers' Compensation Programs (OWCP) denied this claim on August 2, 1994, on the grounds that the Claimant had not established any element of entitlement.[1] DX 1 (DX 27-13). He did not appeal this decision.

On December 13, 1999, the Miner filed a second claim, which was denied by the District Director on June 2, 2000. DX 2; DX 17. On July 28, 2000, the Miner requested modification of this decision denying benefits. DX 20. In a Proposed Decision and Order dated February 2, 2001, the District Director denied this request for modification. DX 25. The Miner requested a formal hearing and his claim was referred to the Office of Administrative Law Judges on May 24, 2001. DX 26, 27. The Miner died on December 9, 2001, and the claim was remanded to the District Director on August 2, 2002, to be consolidated with the Survivor's claim. The claim was returned to the Office of Administrative Law Judges on February 25, 2004. DX 41.

I am issuing a Decision and Order Denying Request for Modification in the Survivor's claim, under Docket Number 2004-BLA-05845, contemporaneously with this Decision and Order.

APPLICABLE STANDARDS

This claim relates to a request for modification of an adverse decision on a "duplicate" claim filed on December 13, 1999. Because the claim at issue was filed after March 31, 1980, the regulations at 20 CFR Part 718 apply. 20 CFR § 718.2 (2006). Parts 718 (standards for award of benefits) and 725 (procedures) of the regulations underwent extensive revisions effective January 19, 2001. 65 Fed. Reg. 79920, *et seq.* (2000). The Department of Labor has taken the position that as a general rule, the revisions to Part 718 should apply to pending cases because they do not announce new rules, but rather clarify or codify existing policy. *See*

[1] In his letter to the Miner, the District Director marked a box indicating that the evidence did not show that the Miner was totally disabled due to pneumoconiosis. A note in an attachment stated that the results of a blood gas study met the requirements for disability, but the evidence did not show that the impairment was due to black lung disease.

65 Fed. Reg. at 79949-79950, 79955-79956 (2000). Changes in the standards for administration of clinical tests and examinations, however, would not apply to medical evidence developed before January 19, 2001. 20 CFR § 718.101(b) (2006). The new rules specifically provide that some revisions to Part 725 apply to pending cases, while others (including revisions to the rules regarding duplicate claims and modification) do not; for a list of the revised sections which do not apply to pending cases, *see* 20 CFR § 725.2(c) (2006). The U.S. District Court for the District of Columbia upheld the validity of the new regulations in *National Mining Association v. Chao*, 160 F.Supp.2d 47 (D.D.C. 2001). However, the Court of Appeals affirmed in part, reversed in part, and remanded the case. *National Mining Association v. Department of Labor*, 292 F.3d 849 (D.C. Cir. 2002) (upholding most of the revised rules, finding some could be applied to pending cases, while others should be applied only prospectively, and holding that one rule empowering cost shifting from a claimant to an employer exceeded the authority of the Department of Labor). On December 15, 2003, the Department of Labor promulgated revisions to 20 CFR §§ 718.2, 725.2, and 725.459 implementing the Circuit Court's opinion. 68 Fed. Reg. 69930, *et seq*. (2003). Accordingly, I will apply only the sections of the newly revised version of Parts 718 and 725 that the Court did not find impermissibly retroactive. In this Decision and Order, the "old" rules applicable to this case will be cited to the 2000 edition of the Code of Federal Regulations; the "new" rules will be cited to the 2006 edition.

Pursuant to 20 CFR § 725.310 (2000), in order to establish that the Miner was entitled to benefits in connection with his current claim, the Claimant must demonstrate that there was a change in conditions or a mistake in a determination of fact such that he met the requirements for entitlement to benefits under 20 CFR Part 718. In order to establish entitlement to benefits under Part 718, the Claimant must establish that the Miner suffered from pneumoconiosis, that his pneumoconiosis arose out of his coal mine employment, and that his pneumoconiosis was totally disabling. 20 CFR §§ 718.1, 718.202, 718.203, 718.204, and 725.103 (2006). I must consider all of the evidence pertaining to his duplicate claim to determine whether there was a change in conditions or a mistake of fact by the District Director; new evidence is not required for me to reach a determination that there was a mistake of fact. *O'Keefe v. Aerojet-General Shipyards, Inc.*, 404 U.S. 254 (1971); *Jessee v. Director, OWCP*, 5 F.3d 723 (4th Cir. 1993).

Because the underlying claim is a duplicate claim, in order to be entitled to benefits, the Claimant must also establish a material change in conditions since the Miner's initial claim was denied. 20 CFR § 725.309(d) (2000). I must consider the new evidence and determine whether the Claimant has proved at least one of the elements of entitlement previously decided against him. If so, then I must consider whether all of the evidence establishes that he was entitled to benefits. *Lisa Lee Mines v. Director, OWCP*, 86 F.3d 1358, 1362-1363 (4th Cir. 1996).

ISSUES

The issues contested by the Employer, or by the Employer and the Director, are:

1. Whether the Miner had pneumoconiosis as defined by the Act and the regulations.

2. Whether his pneumoconiosis arose out of coal mine employment.

3. Whether his total disability was due to pneumoconiosis.

4. Whether the named Employer is the Responsible Operator.

5. Whether the evidence establishes a change in conditions or a mistake in a determination of fact in a prior denial pursuant to 20 CFR § 725.310 (2000).

DX 41; Tr. at 6-7. The Employer withdrew the issues of timeliness, miner, post-1969 employment, total disability, and dependency. Also, the Employer stipulated that the Miner had 23 years of coal mine employment, and that the Miner was totally disabled by a respiratory impairment. Tr. at 6-7.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Factual Background and the Claimant's Testimony

D.V. testified at the hearing held on August 11, 2004, in Beckley, West Virginia. Tr. at 7. She testified that she is the Widow of H.V. and that he passed away on December 9, 2001. Since his passing, the Claimant has not remarried. The Miner's last coal mine work was in 1981 with the Employer's Meadow Creek Mine, located in West Virginia. Therefore, this claim is governed by the law of the Fourth Circuit. *Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1989) (*en banc*). Additionally, the Claimant testified that the Miner started smoking around 1950 at a rate of one pack per day, and quit sometime before leaving the mines in 1981.

The Miner's son testified at the hearing, too. He testified that his father had worked in the coal mines for 26 years. Additionally, he testified that his father was on oxygen constantly for the last 10 years of his life. He testified that his father worked at the tipple and this work was very strenuous due to the heat and lack of ventilation.

Responsible Operator

The Social Security records and other records, including a written statement from a representative of the Employer, DX 6, appearing throughout the file suggest that the Miner began working there in 1948. The evidence supports the conclusion that the Miner was a miner for 23 years, last employed by Mountain Laurel Resources, a mine operator, in 1985. DX 4-8, 21. There is no evidence that Mountain Laurel Resources is unable to assume liability in the event the Claimant is found to be eligible for benefits. I find that Mountain Laurel Resources is the Responsible Operator in this case pursuant to 20 CFR §§ 725.491, 492, and 493 (2006).

Material Change in Conditions

In a duplicate claim, the threshold issue is whether there has been a material change in conditions since the previous claim was denied. The first determination must be whether the Claimant has established with new evidence that he suffers from pneumoconiosis or other pulmonary or respiratory impairment significantly related to or aggravated by dust exposure. Absent a finding that he suffers from such an impairment, none of the elements previously decided against him can be established, and his claim must fail, because a living miner cannot be entitled to black lung benefits unless he is totally disabled based on a pulmonary or respiratory impairment due to pneumoconiosis. As will be discussed in detail below, the Miner was totally disabled by a respiratory impairment when he filed his first claim, because his arterial blood gas

studies resulted in qualifying values. He suffered from that impairment for the rest of his life, as the blood gas studies in the current claim demonstrate. The medical evidence in the initial claim did not show that that Miner had pneumoconiosis. In the current claim, however, I find that the evidence shows that the Miner had legal pneumoconiosis. This constitutes a material change in conditions, and I must, therefore, consider all of the evidence from both claims in reaching my decision.

Medical Evidence

Autopsy

An autopsy may be the basis for a finding of the existence of pneumoconiosis. A finding of anthracotic pigmentation is not sufficient, by itself, to establish pneumoconiosis. 20 CFR § 718.202(a)(2) (2006). Section 718.106(a) provides that an autopsy report shall include a detailed gross macroscopic and microscopic description of the lungs or visualized portion of a lung. If a surgical procedure was performed to obtain a portion of a lung, the evidence should include a copy of the surgical note and the pathology report. It is error to credit a prosector's opinion over those opinions of reviewing pathologists solely on the basis that the prosector examined the miner's whole body at the time of death. *Bill Branch Coal Corp. v. Sparks*, 213 F.3d 186 (4th Cir. 2000).

Dr. S. Gerald Koh performed an autopsy on December 10, 2001. DX 35. Dr. Koh's qualifications are not in the record, and he is not listed on the website of the American Board of Medical Specialties. Based on the macroscopic findings, Dr. Koh found anthracotic pigment in both lungs, but it was more noticeable in the lower parts of the upper lobes and upper parts of the lower lobes. Additionally, Dr. Koh found a large tumor in the right hilum. From the microscopic examination, Dr. Koh found "diffuse distribution of macular aggregates of anthracotic pigments in the subpleural tissue and in the vicinity of bronchovascular bundles." Additionally, during the microscopic examination, Dr. Koh found the "[o]nly residual lymphoid tissue is seen in the periphery with anthracotic deposits therein." Dr. Koh diagnosed bronchogenic carcinoma with multiple metastasis to both lungs, pulmonary congestion and focal interstitial hemorrhage, both lungs, and partial atelectasis of the left lung; "[m]acular pulmonary anthracosis, diffuse, more severe in right lung than the left, consistent with simple coal workers' pneumoconiosis," hydrothorax; and, mild to moderate pulmonary emphysema. He said the terminal events were cardiorespiratory failure, and terminal cancer with widespread metastasis, including the brain.

Dr. Crouch, a Board-certified Pathologist, provided a pulmonary pathology consultation report dated June 20, 2002, based upon the slides Dr. Koh prepared. DX 36. Dr. Crouch has specialized in Pulmonary Pathology. Her microscopic findings were as follows:

> The lungs show multifocal carcinoma consistent with a lung primary. Most of the nodules are well circumscribed and are consistent with intrapulmonary metastases. The uninvolved lung shows relatively mild deposition of irregular black to dark brown particles consistent with coal dust and small numbers of short needle-like birefringent particles consistent with silicates. No coal dust macules, micronodules, or nodules are observed and no silicotic nodules are identified.

Dr. Crouch diagnosed metastatic carcinoma, emphysema, and mild coal dust deposition. Dr. Crouch made the following additional comments:

> Although there is some histologic evidence of coal dust deposition, there is no pulmonary reaction to deposited dust and none of the histological features of coal workers' pneumoconiosis are identified. In particular, no coal dust macules, micronodules or nodules are identified and there is no evidence of massive fibrosis. No silicotic nodules are observed. Thus, occupational dust exposure could not have caused any degree of clinical impairment or respiratory disability and could not have caused or otherwise hastened this patient's death secondary to carcinoma. Limitations of the autopsy preclude a definitive assessment of the primary site of the tumor; metastasis from a distant site cannot be excluded.

Death Certificate

The Death Certificate stated that the Miner passed away on December 9, 2001. DX 35. The immediate cause of death listed was lung cancer with other significant conditions of CLL (chronic lymphocytic leukemia), morbid obesity, and sepsis. The certificate was signed by Dr. M. El-Harake.

Chest X-rays

Chest x-rays may reveal opacities in the lungs caused by pneumoconiosis and other diseases. Larger and more numerous opacities result in greater lung impairment. The following table summarizes the x-ray findings available in connection with both claims.

The existence of pneumoconiosis may be established by chest x-rays classified as Category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. Small opacities (1, 2, or 3) (in ascending order of profusion) may be classified as round (p, q, r) or irregular (s, t, u), and may be evidence of "simple pneumoconiosis." Large opacities (greater than 1 cm) may be classified as A, B, or C, in ascending order of size, and may be evidence of "complicated pneumoconiosis." A chest x-ray classified as category "0," including subcategories 0/-, 0/0, 0/1, does not constitute evidence of pneumoconiosis. 20 CFR § 718.102(b) (2006). X-ray interpretations which make no reference to pneumoconiosis, positive or negative, given in connection with medical treatment, are listed in the "silent" column.

Physicians' qualifications appear after their names. Qualifications have been obtained where shown in the record by Curriculum Vitae or other representations, or if not in the record, by judicial notice of the lists of readers issued by the National Institute of Occupational Safety and Health (NIOSH), or the registry of physicians' specialties maintained by the American Board of Medical Specialties.[2] If no qualifications are noted for any of the following

[2] NIOSH is the federal government agency that certifies physicians for their knowledge of diagnosing pneumoconiosis by means of chest x-rays. Physicians are designated as "A" readers after completing a course in the interpretation of x-rays for pneumoconiosis. Physicians are designated as "B" readers after they have demonstrated expertise in interpreting x-rays for the existence of pneumoconiosis by passing an examination. Historical information about physician qualifications appears on the U.S. Department of Health and Human Services, Comprehensive List of NIOSH Approved A and B Readers, August 29, 2005, found at http://www.oalj.dol.gov/PUBLIC/BLACK_LUNG/REFERENCES/REFERENCE_WORKS/BREAD3_08_05.HTM. Current information

physicians, it means that either they have no special qualifications for reading x-rays, or I have been unable to ascertain their qualifications from the record, the NIOSH lists, or the Board of Medical Specialties. Qualifications of physicians are abbreviated as follows: A=NIOSH certified A reader; B=NIOSH certified B reader; BCR=Board-certified in Radiology. Readers who are Board-certified Radiologists and/or B readers are classified as the most qualified. See *Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 145 n. 16 (1987); *Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276 n.2 (7th Cir. 1993). B readers need not be Radiologists.

Date of X-ray	**Read as Positive for Pneumoconiosis**	**Read as Negative for Pneumoconiosis**	**Silent as to the Presence of Pneumoconiosis**
04/27/94	DX 1 (DX 27-12) Patel B ILO Classification 1/1	DX 1 (DX 27-11) Gaziano B DX 32 Spitz BCR/B DX 30 Wiot BCR/B	
04/12/99			DX 24 Figos Evidence of COPD
11/10/99	DX 24; DX 19 Patel BCR/B ILO Classification 1/0		
02/14/00	DX 16 Patel BCR/B ILO Classification 1/0	DX 16 Gaziano B DX 16 Navani BCR/B DX 30 Wiot BCR/B DX 32 Spitz BCR/B	
02/21/00	DX 16 Patel BCR/B ILO Classification 1/0		
10/17/00			DX 23 Ramos Hilar enlargement bilaterally
09/05/01		DX 31 Zaldivar B (Unclassified. Cancer. Simple pneumoconiosis may be present.[3])	

about physician qualifications appears on the CDC/NIOSH, NIOSH Certified B Readers List found at http://www.cdc.gov/niosh/topics/chestradiography/breader-list.html. Information about physician board certifications appears on the website of the American Board of Medical Specialties, found at http://www.abms.org.

[3] Although Dr. Zaldivar said that he could not rule out simple pneumoconiosis, he did not classify any opacities as required by the regulations. For this reason, I have included his interpretation of this x-ray in the negative column.

CT Scans

CT scans may be used to diagnose pneumoconiosis and other pulmonary diseases. The regulations provide no guidance for the evaluation of CT scans. They are not subject to the specific requirements for evaluation of x-rays, and must be weighed with other acceptable medical evidence. *Melnick v. Consolidation Coal Co*., 16 B.L.R. 1-31, 1-33-1-34 (1991). The record in the current claim contains reports of five CT scans of the Miner's chest.

On April 12, 1999, a CT scan was performed. DX 24. The scan was correlated with a chest x-ray from April 2, 1999. From this scan, Dr. Figueroa opined that there was evidence of COPD and granuloma in the right lower lobe. However, Dr. Figueroa found no evidence of large bullous disease, peribronchial thickening, bronchiectasis, subpleural lines, or pleural effusion.

On April 17, 2000, a follow-up CT Scan was performed for Dr. Lavallee. DX 24, 23. His impression was as follows:

> Prominent soft tissue in infrahilar region of right lung, which most likely represent ectactic vessels. Repeat CT scan and/or bronchoscopy is advised to evaluate for possible right hilar lymphadenopathy or mass.
>
> Mile pleural thickening of both lungs, … A few tiny nodules scattered in both lungs … are unchanged from the previous exam and most likely represent faintly calcified granulomata.

DX 23, 24.

On June 9, 2000, another CT scan was performed by Dr. Williams. DX 24. Dr. Williams noted a "suspect presence of a cluster of lymph nodes or mass involving the right hilar infrahilar location," scattered lymph nodes measuring up to 1.5 cm, and "scattered small 5 mm or less parenchymal nodules … representing nonspecific findings."

Another CT scan was performed for Dr. Lavallee on November 1, 2000. DX 23. The enlarged lymph nodes were noted but were unchanged from the June 9, 2000, scan. Additionally, a soft tissue mass was noted on the right hilum. Overall, the impressions given were that the prominent right hilum was unchanged from previous scans, and that scattered small pulmonary nodules probably represented granulomata.

Pulmonary Function Studies

Pulmonary function studies are tests performed to measure obstruction in the airways of the lungs and the degree of impairment of pulmonary function. The greater the resistance to the flow of air, the more severe the lung impairment. The studies range from simple tests of ventilation to very sophisticated examinations requiring complicated equipment. The most frequently performed tests measure forced vital capacity (FVC), forced expiratory volume in one-second (FEV_1) and maximum voluntary ventilation (MVV).

The following chart summarizes the results of the pulmonary function studies available in both claims. "Pre" and "post" refer to administration of bronchodilators. If only one figure appears, bronchodilators were not administered. In a "qualifying" pulmonary study, the FEV_1 must be equal to or less than the applicable values set forth in the tables in Appendix B of Part 718, and either the FVC or MVV must be equal to or less than the applicable table value, or the FEV_1/FVC ratio must be 55% or less. 20 CFR § 718.204(b)(2)(i) (2006).

Ex. No. Date Physician	**Age Height**[4]	**FEV_1 Pre-/ Post**	**FVC Pre-/ Post**	**FEV_1/ FVC Pre-/ Post**	**MVV Pre-/ Post**	**Qualify?**	**Physician Impression**
DX 1 (DX 27-7) 04/27/94 Rasmussen	64 69"	2.32 2.36	3.16 3.35	73 70	85 102	No No	Minimal, irreversible restrictive and obstructive ventilatory impairment.
DX 24 11/10/99 Kamath	70 71"	1.83	2.64	69%		No	Moderate restriction.
DX 12 02/14/00 Rasmussen	70 69"	2.12 2.23	3.64 3.58	58% 62%	67 67	No No	Minimal, irreversible obstructive ventilatory impairment. Maximum breathing capacity is moderately decreased.
DX 31 09/05/01 Zaldivar	72 70"	1.68 1.99	2.81 3.31	56% 59%		No No	Mild restriction due to obesity. Mild reversible obstruction. Moderate diffusion impairment partly due to the restriction itself.

[4] The fact-finder must resolve conflicting heights of the Miner recorded on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221, 1-223 (1983); *Toler v. Eastern Assoc. Coal Co.*, 43 F.3d 109, 114, 116 (4th Cir. 1995). As there is a variance in the recorded height of the Miner from 69" to 71", I have taken the mid-point (70") in determining whether the studies qualify to show disability under the regulations. None of the tests are qualifying to show disability whether considering the average height, or the heights listed by the persons who administered the testing.

Arterial Blood Gas Studies

Blood gas studies are performed to measure the ability of the lungs to oxygenate blood. A defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. The blood sample is analyzed for the percentage of oxygen (pO_2) and the percentage of carbon dioxide (pCO_2) in the blood. A lower level of oxygen (O_2) compared to carbon dioxide (CO_2) in the blood indicates a deficiency in the transfer of gases through the alveoli which may leave the miner disabled.

The following chart summarizes the arterial blood gas studies available in connection with both claims. A "qualifying" arterial gas study yields values which are equal to or less than the applicable values set forth in the tables in Appendix C of Part 718. If the results of a blood gas test at rest do not satisfy Appendix C, then an exercise blood gas test can be offered. Tests with only one figure represent studies at rest only. Exercise studies are not required if medically contraindicated. 20 CFR § 718.105(b) (2006).

Exhibit Number	**Date**	**Physician**	**pCO_2 at rest/ exercise**	**pO_2 at rest/ exercise**	**Qualify?**	**Physician Impression**
DX 1 (DX 27-9)	04/27/94	Rasmussen	49 47	53 54	Yes Yes	Marked hypoxia and minimal hypercarbia at rest and exercise. Validated by Ranavaya DX 1 (DX 27-10)
DX 11	02/14/00	Rasmussen	45	54	Yes	Marked resting hypoxia. Validated by Dr. Gaziano, DX 13. Unable to exercise.
DX 24	06/12/00	Graeber	50.3	65	Yes	
DX 23	10/17/00	Lavallee	50.0	49.4	Yes	
DX 24	11/28/00	Gaziano	48	55	Yes	Unable to exercise
DX 31	09/05/01	Zaldivar	46	48	Yes	

Medical Opinions

Medical opinions are relevant to the issues of whether the miner had pneumoconiosis, whether the miner was totally disabled, and whether pneumoconiosis caused the miner's disability. A determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis as defined in § 718.201. 20 CFR §§ 718.202(a)(4) (2006). Thus, even if the x-ray evidence is negative, medical opinions may establish the existence of pneumoconiosis. *Taylor v. Director, OWCP*, 9 B.L.R. 1-22 (1986). The medical opinions must be reasoned and supported by objective medical evidence such as blood gas studies,

electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. 20 CFR § 718.202(a)(4) (2006). With certain specified exceptions not applicable here, the cause or causes of total disability must be established by means of a physician's documented and reasoned report. 20 CFR § 718.204(c)(2) (2006). The record contains the following medical opinions submitted in connection with both claims.

Treatment Records

Some of the Miner's treatment records were submitted in connection with the current claim and are found in DX 23 and DX 24.

Outpatient History and Physical Examination records from the West Virginia University Hospitals dated May 16, 2000, records that the Miner consulted that facility due to abnormalities on his CT scan. Further tests were planned. DX 24.

June 9, 2000, outpatient records again noted that the Miner had a mass in the lower lobe of his right lung revealed by CT scan. The treatment plans included consultation with Dr. Lavallee, probable radiation therapy, and a pulmonary evaluation. DX 24.

Additional outpatient notes from August 8, 2000, state that the Miner was offered but declined a biopsy. DX 24.

On August 14, 2000, the Miner was seen by Dr. Lavallee for further evaluation before surgery for his right hilar mass. Due to the risks of surgery, the Miner had elected to wait pending further CT scans. Dr. Lavallee performed a physical examination, and the chest examination was normal. DX 23, 24. Thereafter, the Miner returned to Dr. Lavallee for treatment.

The Miner was seen by Dr. Lavallee on September 28, 2000, for a reevaluation. Dr. Lavallee performed a physical examination, which revealed normal results of the chest. DX 23.

Dr. Lavallee treated the Miner for a chest cold on October 17, 2000. During this visit, Dr. Lavallee again performed a physical examination, which revealed mild congestion in the lungs without rales or wheezes. DX 23.

On October 18, 2000, Dr. Lavallee ordered a chest x-ray, which he opined demonstrated no changes from the previous x-ray and no pneumonia. DX 23.

The Miner returned to Dr. Lavallee again on November 6, 2000, at which time he performed a physical examination and reviewed the Miner's medical history. The chest examination at that examination revealed mild congestion bilaterally without rales or wheezes. DX 23.

Dr. Lavallee saw the Miner on November 13, 2000, to re-evaluate his cough. Office notes indicate that the Miner' home oxygen supplier had been changed to get new equipment and a portable unit.

On January 6, 2001, the Claimant reported that the Miner had a cold, for which Dr. Lavallee prescribed some medication. On January 12, 2001, the Claimant reported that the Miner had a productive cough. Dr. Lavallee prescribed additional medication. DX 23.

Opinions Given in Connection with Black Lung Claims

Dr. Rasmussen examined the Miner on behalf of the Department of Labor on April 27, 1994, in connection with the Miner's initial claim. DX 1 (DX 27-8). According to the American Board of Medical Specialties, Dr. Rasmussen is Board-certified in Internal Medicine. He took occupational, social, family, and medical histories, and conducted a physical examination, chest x-ray, blood gas studies, and pulmonary function testing. He reported that the Miner worked in the mines for 25 years. He reported a smoking history of one pack per day for 40 years. The chest examination revealed that expansion was borderline reduced. Breath sounds were decreased. Dr. Rasmussen relied on Dr. Patel's reading of the x-ray as showing pneumoconiosis, 1/1. The pulmonary function test showed minimal, irreversible, restrictive and obstructive ventilatory impairment. The arterial blood gas study revealed marked hypoxia and minimal hypercarbia at rest and exercise. Dr. Rasmussen diagnosed CWP (coal workers' pneumoconiosis) based on 25 years employment in coal mining and x-ray evidence of pneumoconiosis; chronic hypoxia and hypercarbia; and, COPD (chronic obstructive pulmonary disease) based on mild, minimal airflow limitations. Dr. Rasmussen attributed the CWP to coal mine dust exposure. He said the chronic hypoxia and hypercarbia was due to obesity and possible hypoventilation. He attributed the COPD to coal mine dust exposure and cigarette smoking. He observed that the blood gas results met the listings in the regulations. Asked the extent to which each of his diagnoses contributed to the impairment, he stated,

> The patient's hypoxia and hypercarbia are probably the results of the patient's obesity and possible hypoventilation syndrome. His mild obstructive impairment may be due to coal mine dust exposure and/or cigarette smoking.

In a narrative report, Dr. Rasmussen observed that the blood gas abnormalities appeared:

> … out of proportion to the ventilatory impairment and are probably the consequence of his obesity with initial shunning of blood, the possibility of a simple hypoventilation element cannot be entirely excluded.

See the narrative report accompanying the Medical History and Examination form.

The Miner was seen at Rainelle Medical Center on November 10, 1999, by Dr. Kamath for the purpose of determining whether he was entitled to an increase in his state black lung benefits. DX 24. Dr. Kamath took occupational, social, family, and medical histories, and conducted a physical examination, chest x-ray, and pulmonary function testing. The chest examination revealed decreased breath sounds on each side but no wheezes. The pulmonary function study revealed moderate restriction. Dr. Kamath recommended that the Miner obtain old records of breathing tests so the doctor could compare them to see whether he had a case.

Dr. Rasmussen examined the Miner a second time on behalf of the Department of Labor on February 14, 2000, in connection with the current claim. DX 10. He took occupational,

social, family, and medical histories, and conducted a physical examination, chest x-ray, blood gas studies, and pulmonary function testing. He reported that the Miner worked in the mines for 23 years. He reported a smoking history of one pack per day for 40 years. The chest examination was normal, except for moderately reduced breath sounds. Dr. Rasmussen relied on Dr. Patel's reading of the x-ray as showing pneumoconiosis (ILO Classification 1/0). The pulmonary function test showed minimal irreversible obstructive impairment. The arterial blood gas study revealed marked resting hypoxemia. Dr. Rasmussen diagnosed coal worker's pneumoconiosis based upon 23 years of coal mine employment and the x-ray evidence, and COPD based upon chronic productive cough and airflow obstruction. Dr. Rasmussen attributed the pneumoconiosis to coal dust exposure and the COPD to coal dust exposure and cigarette smoking. He noted that the Miner's resting ABG (arterial blood gases) met the listings in the regulations. He said that "[t]here are several risk factors for the resting hypoxia. These include his coal mine dust exposure, his cigarette smoking and his obesity. The latter is a major contributing factor."

Dr. Zaldivar examined the Miner on behalf of the Employer on September 5, 2001. DX 31. Dr. Zaldivar is Board-certified in Internal Medicine and Pulmonary Disease, and a B reader. He took occupational, social, family, and medical histories, and conducted a physical examination, chest x-ray, blood gas studies, and pulmonary function testing. He reported that the Miner worked in the mines for 23 years. He reported that the Miner started smoking at the age of 17 (1946) at a rate of one pack per day but had not smoked for 18 years (1983). The chest examination was normal. Dr. Zaldivar read the x-ray as compatible with a large mass and bilateral metastatic disease, showing no pneumoconiosis, but said he could not rule out simple pneumoconiosis. The pulmonary function test showed mild obstructive and moderate diffusion impairment. The arterial blood gas study revealed severe hypoxemia due to cancer and obesity. Based upon his examination, Dr. Zaldivar concluded that the Miner was not suffering from coal worker's pneumoconiosis or any other dust disease of the lungs. The pulmonary function and blood gas studies were more consistent with asthma, metastatic cancer, and obesity. Dr. Zaldivar found that the Miner was severely impaired from a pulmonary standpoint and unable to return to work. Dr. Zaldivar opined that this impairment was due to asthma, obesity, and cancer, not pneumoconiosis. He said even if he had simple pneumoconiosis, his opinion would be the same.

Existence of Pneumoconiosis

The regulations define pneumoconiosis broadly:

> (a) For the purpose of the Act, 'pneumoconiosis' means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical,' pneumoconiosis and statutory, or 'legal,' pneumoconiosis.
>
> (1) Clinical Pneumoconiosis. 'Clinical pneumoconiosis' consists of those diseases recognized by the medical community as pneumoconioses, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis,

anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silico-tuberculosis, arising out of coal mine employment.

(2) Legal Pneumoconiosis. 'Legal pneumoconiosis' includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

(b) For purposes of this section, a disease 'arising out of coal mine employment' includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

(c) For purposes of this definition, 'pneumoconiosis' is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

20 CFR § 718.201 (2006).

In this case, the Miner's medical records indicate that he has been diagnosed with chronic obstructive pulmonary disease and emphysema, which can be encompassed within the definition of legal pneumoconiosis. *Ibid*.; *Richardson v. Director, OWCP*, 94 F.3d 164 (4th Cir. 1996); *Warth v. Southern Ohio Coal Co*., 60 F.3d 173 (4th Cir. 1995). However, only chronic obstructive pulmonary disease caused by coal dust constitutes legal pneumoconiosis. *Eastover Mining Co. v. Williams*, 338 F.3d 501, 515 (6th Cir. 2003); 65 Fed. Reg. 79938 (2000) ("The Department reiterates … that the revised definition does not alter the former regulations' … requirement that each miner bear the burden of proving that his obstructive lung disease did in fact arise out of his coal mine employment, and not from another source.").

Twenty CFR § 718.202(a) (2006) provides that a finding of the existence of pneumoconiosis may be based on: (1) chest x-ray; (2) biopsy or autopsy; (3) application of the presumptions described in §§ 718.304 (irrebuttable presumption of total disability/that a miner's death was due to pneumoconiosis if there is a showing of complicated pneumoconiosis), 718.305 (not applicable to claims filed after January 1, 1982), or 718.306 (applicable only to deceased miners who died on or before March 1, 1978); or, (4) a physician exercising sound medical judgment based on objective medical evidence and supported by a reasoned medical opinion. None of the presumptions apply, because the evidence does not establish the existence of complicated pneumoconiosis, the Miner filed his claim after January 1, 1982, and he died after March 1, 1978. I must, therefore, consider the chest x-rays, the autopsy, and the medical opinions. Absent contrary evidence, evidence relevant to any category may establish the existence of pneumoconiosis. In the face of conflicting evidence, however, I must weigh all of the evidence together in reaching my finding whether the Claimant has established that the Miner had pneumoconiosis. *Island Creek Coal Co. v. Compton*, 211 F.3d 203, 211 (4th Cir. 2000).

Autopsy

Autopsy evidence is the strongest evidence on this issue available in this case. Dr. Koh was the prosector and provided a report of his macroscopic and microscopic findings.

Dr. Crouch provided a report after examining the histology slides prepared by Dr. Koh. Both reports conform to the requirements outlined in § 718.106. Both doctors found anthracotic pigment. However, Dr. Koh diagnosed "macular pulmonary anthracosis … consistent with simple pneumoconiosis," while Dr. Crouch said that there was evidence of coal dust deposition, but "no pulmonary reaction to deposited dust and none of the histological features of coal workers' pneumoconiosis … In particular no coal dust macules, micronodules or nodules are identified …" As Dr. Koh's qualifications are not in the record, I cannot evaluate them. The record does document Dr. Crouch's qualifications, and her report is more specific and better explained than Dr. Koh's. For these reasons, I give greater weight to Dr. Crouch's opinion that the Miner did not have pneumoconiosis. Moreover, even were I to accord equal probative weight to each of these reports, they would be in equipoise. As a result, I am unable to find pneumoconiosis on the basis of the autopsy reports.

X-rays

Chest x-rays are less probative than autopsy reports. Of the six available x-rays in this case, some have been read as positive for pneumoconiosis, but there are also negative readings. For cases with conflicting x-ray evidence, the regulations specifically provide,

> … where two or more X-ray reports are in conflict, in evaluating such X-ray reports consideration shall be given to the radiological qualifications of the physicians interpreting such X-rays.

20 CFR § 718.202(a)(1) (2006); *Dixon v. North Camp Coal Co*., 8 B.L.R. 1-344 (1985); *Melnick v. Consolidation Coal Co*., 16 B.L.R. 1-31, 1-37 (1991). Readers who are Board-certified Radiologists and/or B readers are classified as the most qualified. The qualifications of a certified Radiologist are at least comparable to if not superior to a physician certified as a B reader. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211, 1-213 n.5 (1985). Greater weight may be accorded to x-ray interpretations of dually qualified physicians. *Sheckler v. Clinchfield Coal Co*., 7 B.L.R. 1-128, 1-131 (1984). A Judge may consider the number of interpretations on each side of the issue, but not to the exclusion of a qualitative evaluation of the x-rays and their readers. *Woodward*, 991 F.2d at 321; *see Adkins*, 958 F.2d at 52.

Readings of two x-rays taken during treatment did not mention pneumoconiosis, but both reflected abnormalities. I find that these x-rays are neither positive nor negative.

The November 10, 1999, x-ray was read as positive by a dually qualified physician. There are no negative readings. I, therefore, find this x-ray to be positive for pneumoconiosis.

The February 14, 2000, x-ray was read as negative by three dually qualified physicians and one B reader. One dually qualified physician read the x-ray as positive. I find this x-ray to be negative.

The February 21, 2000, x-ray was read as positive by the same dually qualified physician who read the February 14 x-ray as positive. There are no negative readings. I, therefore, find this x-ray to be positive for pneumoconiosis.

The September 5, 2001, x-ray was read as showing cancer by a B reader. He could not rule out pneumoconiosis, but he did not classify any opacities. There are no positive readings. Therefore, I find this x-ray to be negative for pneumoconiosis.

These constitute all of the x-ray interpretations in the record pertaining to the Miner's current claim. The November 1999 x-ray was positive. The February 2000 x-rays were taken only a week apart, and are essentially contemporaneous; I find them to be in equipoise. The most recent x-ray was negative. Thus, I cannot find pneumoconiosis on the basis of the x-ray evidence in the current claim. Nor would this conclusion be changed when I consider all of the x-ray evidence from both claims. The April 27, 1994, x-ray was read negative by two dually qualified physicians and one B reader and positive by one B reader. Giving greater weight to the readings by the dually qualified readers, I find this x-ray to be negative for pneumoconiosis.

Medical Opinions

I must next consider the medical opinions. The Claimant can establish that the Miner suffered from pneumoconiosis by well-reasoned, well-documented medical reports. A "documented" opinion is one that sets forth the clinical findings, observations, facts, and other data upon which the physician based the diagnosis. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). An opinion may be adequately documented if it is based on items such as a physical examination, symptoms, and the patient's work and social histories. *Hoffman v. B&G Construction Co*., 8 B.L.R. 1-65, 1-66 (1985); *Hess v. Clinchfield Coal Co*., 7 B.L.R. 1-295, 1-296 (1984); *Justus v. Director, OWCP*, 6 B.L.R. 1-1127, 1-1129 (1984). A "reasoned" opinion is one in which the Judge finds the underlying documentation and data adequate to support the physician's conclusions. *Fields*, above. Whether a medical report is sufficiently documented and reasoned is for the Judge to decide as the finder-of-fact; an unreasoned or undocumented opinion may be given little or no weight. *Clark v. Karst-Robbins Coal Co*., 12 B.L.R. 1-149, 1-155 (1989) (*en banc*). An unsupported medical conclusion is not a reasoned diagnosis. *Fuller v. Gibraltar Corp*., 6 B.L.R. 1-1291, 1-1294 (1984). A physician's report may be rejected where the basis for the physician's opinion cannot be determined. *Cosaltar v. Mathies Coal Co*., 6 B.L.R. 1-1182, 1-1184 (1984). An opinion may be given little weight if it is equivocal or vague. *Griffith v. Director, OWCP*, 49 F.3d 184, 186-187 (6th Cir. 1995); *Justice v. Island Creek Coal Co*., 11 B.L.R. 1-91, 1-94 (1988); *Parsons v. Black Diamond Coal Co.*, 7 B.L.R. 1-236, 1-239 (1984).

The Miner developed lung cancer in 2000, which his treatment records suggest metastasized quickly thereafter. Although his 1999 CT scan resulted in a diagnosis of COPD, there is no mention of coal workers' pneumoconiosis in any of his treatment records, which related to his treatment after the masses in his lungs were discovered.

As to the opinions given in connection with the black lung claim, although there was a positive x-ray taken in connection with the Miner's examination by Dr. Kamath in November 1999, Dr. Kamath's notes did not contain any diagnosis. Thus, in connection with the current claim, there are only the opinions of Dr. Rasmussen and Dr. Zaldivar to consider.

Dr. Rasmussen opined that the Miner suffered from both clinical and legal pneumoconiosis. Dr. Rasmussen's opinion was based on histories, physical examination, and objective testing. I find his opinion generally to be well documented and well reasoned.

However, Dr. Rasmussen based his opinion of clinical pneumoconiosis on coal mine employment and x-ray evidence which I have found to be negative, due to multiple negative readings by well-qualified readers. Moreover, it is not supported by the inconclusive autopsy results, CT scans, or the treatment records. Thus, his opinion on clinical pneumoconiosis is entitled to less weight. On the other hand, Dr. Rasmussen also diagnosed chronic obstructive pulmonary disease, which he attributed to the combined effects of coal dust exposure and cigarette smoking. If credited, then, this diagnosis falls within the definition of legal pneumoconiosis. Dr. Rasmussen's opinion is well supported by the medical record as a whole, and is consistent with the premise underlying the current regulations that coal dust exposure has an additive effect to obstructive disease caused by smoking. *See* 65 Fed. Reg. at 79938-79939. I find that his opinion on the existence of legal pneumoconiosis is entitled to probative weight.

Dr. Zaldivar did not diagnose either clinical or legal pneumoconiosis, although he said he could not exclude simple clinical pneumoconiosis based on his reading of the x-ray taken at the time he examined the Miner. Like Dr. Rasmussen, Dr. Zaldivar's opinion was based on histories, physical examination and objective testing. I find his opinion is also generally well documented and well reasoned. Although he did not exclude simple clinical pneumoconiosis, I have found that the medical evidence as a whole, including treatment records, CT scans, and the autopsy, is not sufficient to make a showing of clinical pneumoconiosis. On the other hand, Dr. Zaldivar appears to have considered only clinical, but not legal, pneumoconiosis in rendering his opinion. He diagnosed asthma, but not emphysema, which is well documented in the Miner's autopsy, treatment records, x-rays, CT scans, and pulmonary function tests. Nor did he consider whether coal dust may have contributed to the Miner's obstructive disease. Thus, I find that Dr. Zaldivar's opinion cannot be considered on the issue of legal pneumoconiosis.

Weighing all of the relevant evidence in the current claim, I credit Dr. Rasmussen's opinion that the Miner had legal pneumoconiosis, and thus, the Claimant has established a change in conditions since the Miner's initial claim was denied. Moreover, considering all of the evidence from both claims bolsters the conclusion that the Miner had legal, but not clinical, pneumoconiosis. The April 1994 x-ray was negative, as it was read as positive by only one dually qualified reader, but negative by two dually qualified readers and one B reader. The only medical opinion given in connection with the first claim was Dr. Rasmussen's, based on his April 1994 examination of the Miner. At that time, as in 2000, Dr. Rasmussen took histories, conducted a physical examination, and conducted objective testing. Then, as more recently, he diagnosed clinical pneumoconiosis based on a positive x-ray reading which I have found to be negative. Then, as more recently, he attributed the Miner's COPD to the combined effects of coal dust and smoking.

Considering all of the evidence from both claims, positive and negative, I conclude that the Miner suffered from legal pneumoconiosis, in that he had chronic obstructive pulmonary disease caused in part by exposure to coal dust.

Causal Relationship Between Pneumoconiosis and Coal Mine Employment

The Act and the regulations provide for a rebuttable presumption that pneumoconiosis arose out of coal mine employment if a miner with pneumoconiosis was employed in the mines for 10 or more years. 30 U.S.C. § 921(c)(1); 20 CFR § 718.203(b) (2006). The Claimant was employed as a miner for at least 23 years and, therefore, is entitled to the presumption. The

Employer has not offered evidence sufficient to rebut the presumption. Moreover, to the extent that the Claimant has legal, as opposed to clinical, pneumoconiosis, the causal relationship is established by the opinions of Dr. Rasmussen.

Total Pulmonary or Respiratory Disability

The Employer did not contest total disability. All of the Miner's arterial blood gas studies resulted in qualifying values under 20 CFR § 718.204(b)(2)(ii). None of his pulmonary function tests resulted in qualifying values under 20 CFR § 718.204(b)(2)(i). I find that the Miner was totally disabled by a respiratory impairment based on the hypoxia revealed by his blood gas studies, but not by his obstructive disease.

Causation of Total Disability

The current regulations state that unless otherwise provided, the burden of proving a fact rests with the party making the allegation. 20 CFR § 725.103 (2006). The Benefits Review Board has held that § 718.204 places the burden on the claimant to establish total disability due to pneumoconiosis by a preponderance of the evidence. *Baumgardner v. Director, OWCP*, 11 B.L.R. 1-135 (1986). Nothing in the commentary to the new rules suggests that this burden has changed; indeed, some language in the commentary indicates it has not changed. See 65 Fed. Reg. at 79923 (2000) ("Thus, a miner has established that his pneumoconiosis is a substantially contributing cause of his disability if it either has a material adverse effect on his respiratory or pulmonary condition or materially worsens a totally disabling respiratory or pulmonary impairment …"). The Fourth Circuit requires that pneumoconiosis be a "contributing cause" of the miner's disability. *Hobbs v. Clinchfield Coal Co*., 917 F. 2d 790, 791-792 (4th Cir. 1990).

In the present case, the diagnosis of legal pneumoconiosis rests entirely on the opinions given by Dr. Rasmussen. In his 2000 report, Dr. Rasmussen stated that the risk factors for the Miner's resting hypoxia were "his coal mine dust exposure, his cigarette smoking and his obesity. The latter is a major contributing factor." However, he did not state whether the Miner's coal mine dust exposure was or was not a contributing cause. Moreover, in his 1994 report, Dr. Rasmussen stated that the Miner's chronic hypoxia was due only to obesity and possible hypoventilation. He did not identify coal dust exposure as a risk factor for the Miner's disability in that report. The apparent inconsistency between the reports is not explained. I find that the evidence from Dr. Rasmussen on the cause of the Miner's hypoxia is insufficient to establish that coal dust was a contributing factor. There is no other evidence linking his coal dust exposure to his disability.

I find that the Claimant has failed to prove that the Miner's disability was caused or contributed to by coal dust exposure. For this reason, the Miner's claim must fail.

FINDINGS AND CONCLUSIONS REGARDING ENTITLEMENT TO BENEFITS

Because the Claimant has failed to meet her burden to establish that exposure to coal dust contributed to the Miner's respiratory disability, the Claimant is not entitled to benefits on behalf of the Miner under the Act.

ORDER

The for request for modification filed by the Claimant on July 28, 2000, is hereby DENIED.

A

ALICE M. CRAFT
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the Administrative Law Judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the Administrative Law Judge's decision is filed with the District Director's office. *See* 20 C.F.R. §§ 725.478 and 725.479. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, D.C., 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, D.C., 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the Administrative Law Judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).